DRAFT

Analysis of Wisconsin Medicaid and BadgerCare Dental Service Delivery Systems

March 23, 2005

Introduction:

The Department of Health and Family Services (the Department) recognizes that many Wisconsin Medicaid and BadgerCare clients have great difficulty accessing needed dental care. This is a persistent problem that involves the amount of money budgeted to Medicaid dental services, but is also closely intertwined with larger issues of workforce, geography, and the economics of the dental profession.

Following the lead set by Governor Doyle, who set children's oral health as a priority in his KidsFirst agenda, the Department's Division of Health Care Financing (DHCF) began an extensive analysis in 2003 of the performance of Wisconsin's various dental delivery systems. Since it is not expected that substantial new funding will be available for dental reimbursement, it is imperative that the state use currently-budgeted funds on delivery systems that most effectively get services to the clients that need them. If other Wisconsin efforts, such as Governor Doyle's Task Force on Access to Oral Health Care, result in increased funding for dental care, the state must still have assurance that new investments result in increased performance.

This analysis compares the managed care dental delivery system that operates in the four southeastern counties around Milwaukee to the fee-for-service system that operates in the rest of the state. In managed care, Health Maintenance Organizations (HMOs) are paid a monthly amount per person for every Medicaid or BadgerCare enrollee (capitation rate). In the fee-for-service system, individual dentists submit claims to, and are paid by, the Department's fiscal agent according to a set schedule of fees. A comparison of the two reveals a complex picture of the situation facing Medicaid and BadgerCare clients.

Based on data from 2003, children enrolled in HMOs that provide dental care appear somewhat less likely than their fee-for-service counterparts to receive dental care. HMO-enrolled adults, however, appear somewhat more likely than fee-for-service clients to be seen by a dentist. Moreover, being enrolled continuously in the same HMO for more than ten months appears to improve access to preventive dental care for clients of all ages above the level attained under the fee-for-service model.

DHCF also analyzed the dental portion of the capitation revenues that the HMOs receive relative to the amount of dental care actually provided in 2003. Pricing HMO-reported dental encounters at Medicaid fee-for-service reimbursement rates shows that if the services reported by the HMOs were provided in the fee-for-service system, the Department would have paid $2.7 million less than it did for dental services provided by HMOs during SFY 2003.

The Department believes that the HMO delivery system can be reformed to align payment rates with current levels of service utilization, and to use the remainder as pay-for-performance incentives. Neither the HMO nor the fee-for-service delivery system is operating at the level that the Department would desire; however, the HMO system is improving, especially among continuously-enrolled clients, and there are notable advantages to a managed care model that advise its continuance. Most important are contractual guarantees that the Department can enforce to ensure that patients in need of dental care will be provided that care.

In the longer term, other dental delivery models exist that are worth further investigation. Most notable is the "carve-out" option, where the Department would contract with a specialized dental benefits administrator for claims processing and customer service. Several other states have pursued this option, which would likely incur administrative costs beyond the state's current fiscal agent contract. Although "carve-outs" seem to have their best results when accompanied by very large rate increases, such a strategy may be able to provide improvements that might warrant the additional expense.

Key Recommendations for Medicaid Dental Administration:

1. Emphasize that future investments in the Medicaid dental program should be spent in pay-for-performance strategies that assure increased access, regardless of the delivery system.
2. Reform the HMO delivery system, and strengthen contractual guarantees not available in the current fee-for-service delivery system to improve the level of service provided to clients.
3. Fully investigate the "carve-out" option, including the development of a request for information on a contract for statewide dental benefits administration.
4. Support the efforts of the Governor's Task Force on Access to Oral Health Care.

Background:

History

Medicaid Dental Benefit Overview

Under federal Medicaid rules, basic dental services are an optional benefit for adults and a required benefit for children when found necessary by an EPSDT (HealthCheck) screening. Wisconsin is one of about ten state Medicaid programs that maintains a fairly comprehensive dental benefit for both adults and children. Access to dental care, however, has been a persistent problem for Wisconsin Medicaid clients for more than 20 years. In any year during that period, no more than 30 percent of clients eligible for a dental benefit have actually received dental services, which is far below the 50 percent utilization rate for people with commercial dental insurance. It is not, however, out of line with the experience of most other state Medicaid programs.

Overall, the Healthy People 2010 project reports that in 1996, 44 percent of persons aged 2 years and older visited a dentist during the previous year.

Dentists' Practice and Workforce
Many of the problems that state Medicaid programs face in regard to dental care can be traced to differences between the economic and clinical realities of the medical and dental professions.

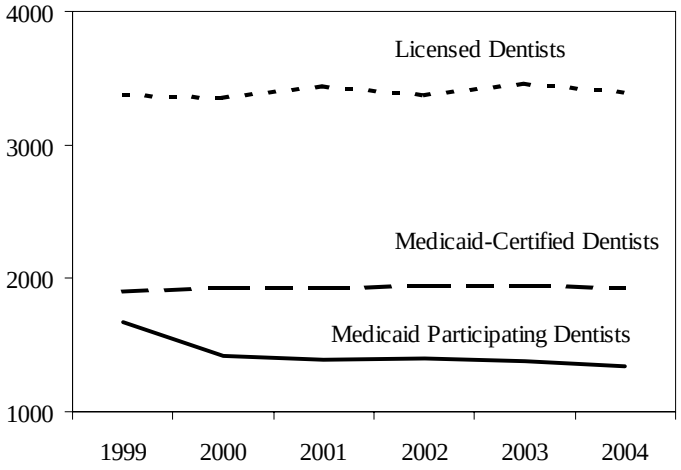
A large number of dentists are self-employed or work with only one partner, in small practices with limited patient pools and limited flexibility in scheduling. Forty-six percent of dentists responding to the 2001 Wisconsin Dentist Workforce survey report that they are "solo" practitioners. It means that these owning dentists are responsible for the maintaining the financial viability of their business, and are at substantial risk for lost income if revenues fail to meet overhead expenses, or if patient appointments are missed without adequate prior notice.

Dentists also have a very different experience with insurance programs than physicians do. Only 44 percent of persons in the United States have some form of private dental insurance, most with limited coverage and with high copayments. Nine percent have dental insurance through state Medicaid programs, 2 percent have other dental insurance, and 45 percent – more than 100 million people – have no dental insurance at all.

Furthermore, there are important structural workforce issues at play. The ratio of dentists to the overall United States population has been falling for the last decade, and has been exacerbated by the closure of several dental schools. In 2001, Wisconsin's ratio of dentists per 10,000 citizens ranged from 5.6 in the southeast to 4.2 in the south and southwest. The dentist workforce is also aging; fully 35 percent of the dentists responding to the 2001 Workforce Survey anticipated retiring by 2011.

In state fiscal year 2004, only 40 percent of Wisconsin's licensed dentists (about 1,300 dentists out of 3,400) submitted any claims to the fee-for-service Medicaid program. Dentists continue to cite the same reasons for non-participation that they have for more than two decades: low reimbursement, administrative burden, and patient behaviors. Chart 1 below shows the decline in the number of dentists submitting Medicaid claims since 1999, even as the number of Wisconsin licensed dentists and Medicaid-certified dentists have stayed fairly constant.

Chart 1: Dentist Participation, Fee-for-Service Program, SFY 1999-2004



Previous Efforts

Wisconsin has made several attempts to improve dental access for Medicaid and BadgerCare clients. In the 1990s, dentists received multiple rate increases between 5 and 10 percent, some of which were targeted specifically for children's dental services. The Department also engaged in joint provider recruitment and education efforts with the Wisconsin Dental Association (WDA). Additionally, from 2001 to 2003, the state's fiscal agent provided a specialized customer service unit to assist dentists billing Medicaid. These initiatives had no discernible impact on dentist participation in Medicaid. In the late 1990s, the Department attempted to start a managed care pilot for dental services in northern Wisconsin; however, capitation rates based on historic fee-for-service costs, with an incentive component and an administrative allowance, were viewed as less than satisfactory by northern dentists. This initiative was never implemented. At the same time, the passage of SCHIP and EPSDT legislation, and release of the 2001 Surgeon General's report on oral health put new emphasis on dental care being essential to children's overall health.

In 2000, the Joint Legislative Council convened a study committee that produced two bills: a fiscal bill that would have raised fees to the level desired by WDA, and a non-fiscal bill comprised of several measures, including increased scope of practice for dental hygienists. Neither bill was enacted into law. In October 2004, Governor Doyle convened a Task Force on Access to Oral Health Care, which will report its recommendations in May.

It is expected that the Governor's Task Force will put forth recommendations including an expansion of the settings where dental hygienists can provide preventive care, an expansion of the number of Wisconsin students attending the Marquette University School of Dentistry, and increases to loan forgiveness opportunities for dentists and dental hygienists. They may also support a WDA-proposed "Two Cents for Tooth Sense" tax on soda that would provide program revenue to increase the Medicaid dental program's reimbursement rates.

Dental Care Delivery Systems

In SFY 2004, Wisconsin spent approximately $38 million for dental services provided to Medicaid and BadgerCare clients. Of this amount, approximately $28 million (75 percent) was for dental services provided under fee-for-service. Approximately $10 million (25 percent) was distributed to health maintenance organizations (HMOs) for enrollees.

Medicaid HMOs have the option of offering dental services to their enrollees. Currently, only three HMOs serving in Milwaukee, Waukesha, Racine, and Kenosha counties cover dental services. Approximately 166,000 clients are enrolled in HMOs in these counties (48 percent of HMO enrollees, 25 percent of clients eligible for dental benefits). Approximately 493,000 clients (75 percent of clients eligible for dental benefits) in the other 68 Wisconsin counties receive fee-for-service dental benefits administered by the state's fiscal agent, EDS.

Fee-for-Service

In the fee-for-service system, clients are responsible for locating Medicaid-certified dentists, and calling them to see whether they are accepting new patients. Very few dentists are, and most that do place restrictions on admissions by patient age or place of residence, and dismiss patients from their practice for missed appointments.

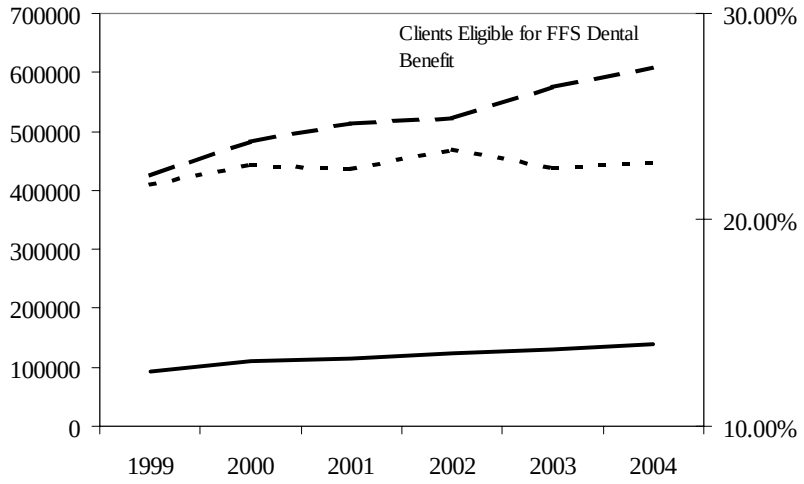
Clients report significant frustration in finding dental care. The Medicaid fiscal agent receives more than 1,000 calls per month from clients seeking care. DHCF, the Department, and the Office of the Governor receive between five and ten pieces of written correspondence per month regarding access to dental care. DHCF and Department staff attempt to broker services for fee-for-service clients in need, but their ability to do so is limited.

In state fiscal year 2004, about 23 percent of clients eligible for fee-for-service dental benefits received at least one dental service. This percentage has remained steady for the last several years, even with caseload increases. In SFY 2004, Medicaid fee-for-service payments were roughly equal to 46 percent of dentists' billed charges. Rates for dentists have not increased since SFY 2003, when dentists received a one percent increase.

DHCF is pursuing several initiatives to improve the fee-for-service program. DHCF is recertifying dentists to ensure that contact information for only those dentists that are accepting new patients is provided to clients, in order to decrease clients' and providers' frustration with fruitless telephone calls. In addition, DHCF is advancing rule changes to reduce the number of services requiring prior authorization to address the "administrative burden" concern, and to certify independently-practicing dental hygienists as Medicaid providers.

Chart 2 shows that the number of unduplicated fee-for-service clients receiving dental services has increased slightly in each year since SFY 1999. However, the percent of clients receiving dental services has remained at approximately 23 percent because the number of unduplicated eligibles has been rising steadily. (Note that this is a count of every person who was eligible for Medicaid or BadgerCare fee-for-service dental benefits in a year, and will be much greater than the average enrollment for a year.)

Chart 2: Client Access to Care, Fee-for-Service Program, SFY 1999-2004



Because of the limited access to care in the fee-for-service system, a set of volunteer and not-for-profit dental clinics has emerged across the state in recent years. These clinics are a major reason why access has kept pace with expanding enrollment, even with declining participation by private dentists. These clinics include state-subsidized clinics like the Rural Health Dental Clinic in Menomonie, which uses state and federal appropriations to employ dental staff; volunteer clinics like the Tri-County clinic in Appleton and the dental hygiene clinic at the Chippewa Valley Technical College, where volunteer dentists and students provide care to Medicaid clients, but personally incur no overhead expenses; and Federally Qualified Health Centers (FQHCs) like those in Wausau and Ladysmith, which are eligible for cost-based reimbursement under Medicaid.

FQHCs are required to accept Medicaid clients and the uninsured, and are reimbursed for 100 percent of the allowable cost of providing care to Medicaid clients. Several rank among the most productive providers of dental services to Wisconsin Medicaid. The yearly cost settlements represent a significant expenditure by the Medicaid program. Based on the federal fiscal year 2003 experience of one FQHC dental clinic, the cost settlement can approximately double the payment made by Medicaid.

Managed Care

In the managed care system, the three HMOs serving southeastern Wisconsin (Network, UnitedHealthcare, and Managed Health Services) subcontract with two dental benefits managers, Doral Dental or Southeast Dental Associates (SEDA), to provide dental care for their Medicaid members.

DHCF's contracts with HMOs include a number of provisions intended to ensure adequate access to dental services for enrollees. These requirements include maintaining adequate provider networks, informing enrollees of their dental benefits, and ensuring that they have access to routine care within 90 days and emergency care within 24 hours. In addition, enrollees have access to ombudsmen, who advocate on behalf of the enrollee to ensure that the enrollee receives needed services, and grievance processes at the HMO and the Department if they have problems obtaining dental services.

DHCF monitors HMOs' performance on dental access and utilization in several ways. Encounter data in MEDDIC-MS is used to analyze utilization and consumer satisfaction is measured through use of the CAHPS® survey. Additionally, DHCF performs audits to determine the sufficiency of the HMOs' dental networks, monitors grievances filed by enrollees, requires HMOs to conduct additional dental outreach and case management services, and requires HMOs to implement a dental education initiative for parents and guardians.

Analysis of HMO Dental Encounters and Provider Revenue:

Background

Throughout 2003 and 2004 the Department has received complaints that HMOs have not been providing sufficient access to dental care. In early 2004, DHCF initiated a review of the cost of the managed care dental delivery system relative to services provided, to assess the extent to which the services provided corresponded to the capitation payments, and how utilization and access compared with fee-for-service. The Governor has since convened a Task Force on Oral Health Care, where the HMO dental contracts became a major point of discussion. The issue was also brought before the Legislature's Joint Audit Committee. On March 8, 2005, that committee directed the Legislative Audit Bureau to begin an inquiry into the matter in the near future.

Conclusions

The Department analyzed a variety of data about dental care provided to HMO enrollees and compared it to low-income family Medicaid and BadgerCare fee-for-service clients. The analysis yielded the following conclusions:

- It appears that HMO-enrolled children were less likely to receive dental care than children receiving fee-for-service dental benefits in 2003. HMO-enrolled adults, by comparison, were more likely to receive dental care than their fee-for-service counterparts.
- Among clients receiving care, HMO enrollees received approximately the same number of dental services as fee-for-service clients.

- Pricing HMO-reported dental encounters at fee-for-service rates shows that if the services reported by the HMOs were provided in the fee-for-service system, the Department would have paid $2.7 million less than it did for dental services provided by HMOs during SFY 2003.
- However, delivery of preventive dental care by HMOs to children who have been enrolled in the same HMO for at least ten months has increased over the last several years, to levels exceeding those of the comparable fee-for-service population.
- HMO enrollees who receive dental services report high satisfaction with the service delivery system, and there is little evidence of unresolved grievances related to inability to access dental care.

Discussion

Comparing HMO and FFS Users of Dental Services

Table 1 shows that, compared to the HMO Family Medicaid population, fee-for-service clients are significantly more likely to use dental services than HMO enrollees. During SFY 2003, HMO Medicaid enrollees had 15.5 percent fewer dental users per 1,000 members than fee-for-service clients did. The lower utilization was most pronounced in children between the ages of 6-14 years of age.

Table 2 shows that, for BadgerCare in SFY 2003, 7.4 percent more HMO enrollees per thousand members used dental services than did fee-for -service enrollees. The higher utilization is most pronounced in adults ages 21-34 years, but for children ages 6-20 years, HMO utilization still fell below fee-for-service levels.

Note that Tables 1 and 2 contain information on utilization rates. In terms of real users, HMO utilization was higher in every group except BadgerCare adults 35 years and older.

Table 1: Net Difference in Dental Users per 1,000 Members, AFDC/Healthy Start, SFY 2003

Age Range	HMO Users	FFS Users	HMO Users Per 1000 Members	FFS Users Per 1000 Members	Net HMO - FFS Difference	Percent Difference
0	15	18	1.58	2.66	(1.07)	-40.4%
1-5	8,105	6,719	218.75	264.81	(46.06)	-17.4%
6-14	13,743	10,257	328.47	445.29	(116.82)	-26.2%
15-20	3,814	2,889	240.68	334.49	(93.81)	-28.0%
21-34	5,845	2,918	330.56	303.38	27.18	9.0%
35+	2,701	1,588	321.33	316.69	4.64	1.5%
TOTAL	**34,223**	**24,389**	**262.64**	**310.87**	**(48.23)**	**-15.5%**

Table 2:
Net Difference in Dental Users per 1,000 Members, BadgerCare, SFY 2003

Age Range	HMO Users	FFS Users	HMO Users Per 1000 Members	FFS Users Per 1000 Members	Net HMO - FFS Difference	Percent Difference
0	-	-	-	-	-	-
1-5	83	72	289.62	286.19	3.43	1.2%
6-14	3,335	2,818	452.44	479.71	(27.27)	-5.7%
15-20	915	937	312.68	349.02	(36.34)	-10.4%
21-34	3,437	2,571	354.18	288.29	65.90	22.9%
35+	2,498	3,345	334.38	317.96	16.42	5.2%
TOTAL	**10,268**	**9,743**	**369.90**	**344.58**	**25.33**	**7.4%**

Comparing the Number of Services Received by HMO and FFS Dental Users
An analysis of the amount of dental services used by clients who had at least one dental service during SFY 2003 showed very similar utilization patterns between HMO and fee-for-service clients of all ages. Family Medicaid clients used 5.16 dental services per user in fee-for-service while HMO enrollees used 5.15 dental services per user. For BadgerCare, fee-for-service clients used 4.81 services per user while HMO enrollees used 5.04 services per user.

Table 3: Services Per User, Fee-for-Service and HMO Clients, SFY 2003

AFDC /Healthy Start				**BadgerCare**			
Age Range	FFS	HMO	HMO less FFS	Age Range	FFS	HMO	HMO less FFS
0	1.17	1.60	0.43	0	-	-	-
1-5	4.67	5.18	0.51	1-5	3.47	4.28	0.81
6-14	5.34	5.28	(0.06)	6-14	4.76	5.09	0.33
15-20	5.21	4.89	(0.32)	15-20	5.17	4.72	(0.45)
21-34	5.12	4.95	(0.17)	21-34	4.81	5.05	0.24
35+	4.61	5.28	0.67	35+	4.72	5.08	0.36
All Ages	5.16	5.15	(0.01)	All Ages	4.81	5.04	0.23

Comparing HMO Revenue to Expected FFS Payments
Capitation rates for dental services have been set using 1996 baseline data for the four southeastern counties, increased annually by the rate of growth in the fee-for-service system in the rest of the state. Budgeted rate increases, like the 4.2 percent increase for AFDC/Healthy Start enrollees in 2003, have been proportionally applied to all portions of the rate – medical, dental and chiropractic. The recent improvement in the quality of dental encounter data has made possible a comparison of capitation payments and the expected cost of providing the same services under the fee-for-service delivery system.

The Department assigned costs to the encounter data using fee-for-service Medicaid Allowable Fees, priced the HMO encounter data using those fees plus a 15 percent administrative allowance, and compared the encounter data to revenues received by the HMOs that accept dental services. Chart 4 shows that the dental portion of HMOs' capitation rate is significantly higher than the cost of services the HMOs provide priced at fee-for-service rates. If those same services reported by the HMOs were provided in fee-for-service, the Department would have paid $2.7 million less than it did for dental services provided by HMOs during SFY 2003.

Table 4: Net HMO Dental Revenue, Including Administration Revenue, SFY 2003

	Kenosha	Milwaukee	Racine	Waukesha	Total
Total HMO Dental Revenue	$937,338	$8,217,411	$434,281	$484,583	$10,073,613
HMO Dental Encounters Priced at FFS	$767,923	$6,009,300	$306,479	$285,692	$7,369,394
Difference	$169,415	$2,208,111	$127,802	$198,891	$2,704,218
Difference as a percent of Revenue	18.1%	26.9%	29.4%	41.0%	26.8%

It should be noted that the priced encounter data represents what fee-for-service would have paid, not what HMO actually paid for the services reported. HMO payment rates to providers constitute proprietary information and may not be related to fee-for service payment rates.

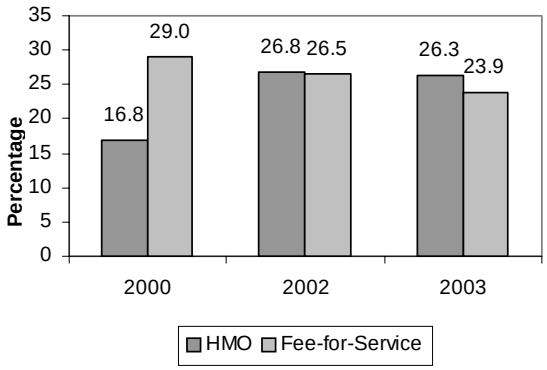
In addition, HMOs that provide dental services are paid one global capitation rate to manage all medical and dental services. The dental part of the capitation rate is less than 5% of the total rate. Effectively, the surplus realized in dental services may be subsidizing the cost of medical services.

Other Measures of HMO Service Delivery

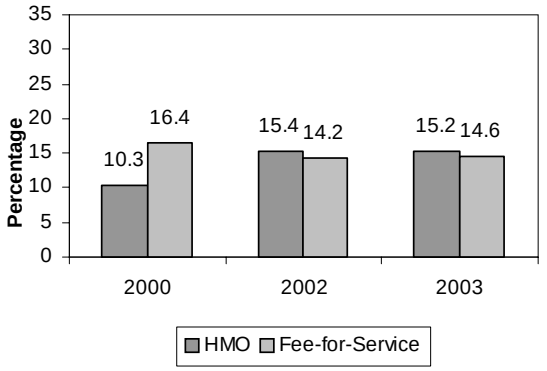
The Department also examined three years of HMO dental preventive care performance measures for individuals enrolled for ten consecutive months using the MEDDIC-MS system. This review shows that utilization of preventive dental care among this population is trending upward. Chart 3 shows that from calendar year 2000 to 2003, dental care increased nearly 10 percentage points among children 3-21 years of age to 26.3 percent, and about 5 percent among enrollees over age 21 years to 15.2 percent. This is now better than the experience of clients enrolled for 10 consecutive months in the fee-for-service system, where 23.9 percent of children aged 3-21 years and 14.6 percent of clients over age 21 received preventive dental care in 2003.

Chart 3: HMO and Fee-for-Service MEDDIC-MS Measures of Preventive Dental Care, SFY 2000, 2002, 2003

A. Clients Ages 3-20 Years



B. Clients 21 Years and Older



The Department also measures HMO enrollees' satisfaction with managed care every two years through the CAHPS® Satisfaction Survey. Survey results from 2000 and 2002 show that, for those enrollees who received dental care through HMOs, nearly 7 out of 10 rated the quality of the dental care they received 8 or higher on a scale of 0 (worst) to 10 (best). While most respondents said they visited a dentist once in the past six months, nearly a quarter of respondents who used dental services reported having two visits, about seven percent had three visits and about three percent had four visits. Some enrollees had ten or more visits.

HMO enrollees may file informal complaints by telephone or grievances in writing with their HMO. Enrollees may also file grievances directly to the Department or fair hearing. A review of the grievances the State received for dental care provided through HMOs shows that cases elevated to the Department have been exclusively for denied orthodontic treatment, and not related to access to preventive or restorative dental care. The number of grievances for orthodontic treatment is comparable to the number of grievances for denial of non-dental services.

A review of the HMOs' phone logs for calendar years 2002-2004 indicates that the majority of complaints were for enrollees looking for a dentist, which the HMO logs indicate were resolved. This is a very different experience from the fee-for-service system, where care cannot be guaranteed.

Alternatives to the Managed Care Dental Care Delivery System

As the state and the Governor's Task Force on Access to Oral Health Care contemplate the conclusions to draw from this analysis, it is important to note several available courses of action.

Improve Managed Care

Under this scenario, the state could re-calculate the dental capitation rates to better reflect actual performance. The remainder could be withheld, and be paid to the HMOs only if they meet or exceed targets for improved utilization and access. This strategy, similar to the one used by DHCF for HealthCheck services, allows payments to be clearly linked to performance. If service delivery improves, then the HMOs earn back the additional funds. If it does not improve, DHCF can redirect the money to other initiatives to improve access to care.

Revert to Fee-for-Service

If the HMO delivery system were judged to be not worth improving, the state could remove dental services from the HMOs' contracts, and place all 166,000 Medicaid and BadgerCare clients in the four southeastern counties back into the fee-for-service system administered by EDS. This would remove the concern of losing funds to administrative overhead that could be directed to service delivery. However, it would also remove the contractual guarantees that the HMO contracts provide, and place responsibility for locating care squarely on the programs' clients. It seems unlikely at this point that sufficient capacity exists in the fee-for-service dental network to absorb such a large influx of clients at current reimbursement rates.

The funds currently dedicated to administrative costs for the dental HMO contracts could be directed to fee increases in the fee-for-service system. However, the amount of money involved is unlikely to constitute a large enough increase to attract significant interest from dentists. A study of North Carolina's experience in the late 1990s showed that even a 23 percent increase in fees only resulted in a 3 percent increase in participation among dentists. Several other states, including New York, had similar experiences, and Wisconsin's own history of rate increases tells a similar story.

It is the contention of national and state dental associations that very large rate increases are necessary to attract dentists to participate in Medicaid programs. There is evidence from several states, including Alabama and Indiana, that raising fee-for-service rates close to full private practice rates does result in improved access for clients. This is, however, a very expensive option, which would require new investment of tens of millions of dollars in the Medicaid dental program. It is unlikely that such funds are available at this time.

"Carve-Out" Dental Administration

There is a third option to consider, which has been advanced by several dentists and advocacy groups – a "carve-out" of dental administration that would remove dental claims processing and customer service from both the HMO and fee-for-service systems. The state would contract with a specialized dental benefits administrator for provision of these services and maintenance of a dental provider network. Such a contract could better recognize the unique circumstances of the dental profession, and include greatly enhanced support in correcting dental billing errors and providing dentistry-specific clinical expertise. It could also include enforceable benchmarks regarding utilization and access targets, and expanded customer outreach and education requirements.

States such as Michigan, Illinois, Tennessee, and Kansas employ variations of this strategy. It seems to have been most effective in the cases of Michigan and Tennessee, when the administrative change was accompanied by a large increase in reimbursement.

A new contract would require new funding. Illinois' contract for dental administrative services costs approximately $.37 per enrollee per month, and Tennessee's costs approximately $.75 per child per month (they also pay $.10 per adult per month, but Tennessee has a very limited adult dental benefit). It is unlikely that significant funds could be recouped from the recently-bid fiscal agent contract, because the amount of resources dedicated to dental administration is a very small proportion of the total.

In order to fully understand the costs and benefits of a "carve-out," the Department would need to engage in a formal request for information to gauge the level of interest from possible bidders, and the extent of services they could bring to the table.

Recommendations

1. Emphasize that future investments in the Medicaid dental program should be spent in pay-for-performance strategies that assure increased access, regardless of the delivery system. In a restrictive fiscal environment, it is imperative that every dollar of funding positively impact service delivery. The Department must ensure that money is spent appropriately, in ways that verifiably work for our clients.

2. Reform the HMO delivery system, and strengthen contractual guarantees not available in the current fee-for-service delivery system to improve the level of service provided to clients. In the short term, the Department should not abandon the HMO contracts, which provide valuable provisions that allow patients in need to access care. The Department can, however, make these contracts work better by realigning payments to HMOs to match utilization, and withholding the remainder if utilization increases are not delivered.

3. Fully investigate the "carve-out" option, including the development of a request for information on a contract for statewide dental benefits administration. Direct contracting with a dental benefits administrator is a strategy that has worked for several other states; the Department should determine whether investing in this strategy will produce positive results for Wisconsin's Medicaid and BadgerCare clients at an affordable price.

4. Support the efforts of the Governor's Task Force on Access to Oral Health Care. The Department fully supports Governor Doyle's ranking of children's oral health as a priority. We look forward to working to evaluate and implement the Task Force's recommendations.